Frequently Asked Questions

Deficit Reduction Act (DRA) Hospital-Acquired Condition (HAC) Reporting

2019

Contents

General Information

1. What is a HAC?

A hospital-acquired condition (HAC) is one of several medical conditions a patient can acquire during a hospital stay that was not present on admission (POA). The Centers for Medicare & Medicaid Services (CMS) have used this designation since October 1, 2008, which may result in adjustments to Medicare Severity Diagnosis-Related Group (MS-DRG) hospital payments.

2. What is the history of DRA HAC measure reporting?

Section 5001(c) of the Deficit Reduction Act (DRA) of 2005 requires the Secretary of the Department of Health and Human Services (HHS) to identify HACs that are (a) high-cost, high-volume, or both; (b) result in the assignment of a case to a Diagnosis Related Group (DRG) that has a higher payment when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. On July 31, 2008, CMS selected ten categories of conditions for application of the DRA HAC payment provision in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule. CMS expanded the DRA HAC categories in the FY 2013 IPPS Final Rule to include 14 categories of HACs. For discharges occurring on or after October 1, 2008, hospitals no longer receive additional payment for cases in which one of the selected conditions occurred but was not present on admission (POA). The case will be paid as though the condition(s) were not present.

In August 2018, CMS calculated and publicly reported four of the 14 DRA HAC measures (see Question 7) on the CMS website (https://data.cms.gov). CMS will publicly report the same four DRA HAC measures in August 2019. Please see Question 4 for more details on the differences between the 2018 and 2019 DRA HAC public reporting.

3. What is the difference between the DRA HAC Payment Provision, DRA HAC Reporting, and the HAC Reduction Program?

Under the DRA HAC payment provision, established by Section 5001(c) of the DRA of 2005, hospitals no longer receive additional payment for cases in which one of the selected conditions occurred but was not present on admission (POA). That is, the case is paid as though the condition were not present. The DRA HAC-POA payment provision is applicable for secondary diagnosis code reporting only, as the selected conditions are designated as a complication or comorbidity (CC) or a major complication or comorbidity (MCC) when reported as a secondary diagnosis. For the DRA HAC-POA payment provision, a payment adjustment is only applicable if there are no other CC/MCC conditions reported on the claim.

CMS calculates and reports rates for four of the conditions included in the DRA HAC payment provision; this is referred to as DRA HAC Reporting. The public reporting of the DRA HAC measures is distinct from the HAC Reduction Program, which was established by Section 3008 of the Affordable Care Act of 2010.The DRA HAC measures are not a part of the HAC Reduction Program and are only reported for information and quality improvement purposes.

The HAC Reduction Program is a separate Medicare pay-for-performance program that supports CMS's long-standing effort to link Medicare payments to healthcare quality in the inpatient hospital setting. Section 1886(p)) of the Social Security Act established the statutory requirements for the HAC Reduction Program.

Beginning with Fiscal Year FY 2015 discharges (i.e., effective October 1, 2014), the HAC Reduction Program requires the Secretary of Health and Human Services (HHS) to adjust payments to hospitals that rank in the worst-performing 25 percent of all subsection (d) hospitals with respect to HAC quality measures. Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction.

4. How will the DRA HAC results posted in August 2019 differ from the results from August 2018?

2019 DRA HAC Reporting used an updated 24-month performance period to include discharges from July 1, 2016 through June 30, 2018. 2018 DRA HAC Reporting used a shortened 21-month performance period to only use ICD-10 codes for discharges from October 1, 2015 through June 30, 2017.

Public Reporting

5. Which DRA HAC measures will CMS report in August 2019?

For 2019, CMS will publicly report the following DRA HAC measures:

- Foreign Object Retained After Surgery
- Blood Incompatibility
- Air Embolism
- Falls and Trauma

6. Why is CMS reporting DRA HAC measures?

CMS is publicly reporting the DRA HAC measures to identify complications and undesirable conditions patients experience in hospital settings that hospital-level changes can reasonably prevent. Improving patient safety is one of the ultimate goals of quality improvement. The DRA HAC measures remain an important aspect of CMS's commitment to patient safety.

7. Why is CMS only reporting four DRA HAC measures?

CMS selected the four DRA HAC measures—Foreign Object Retained After Surgery, Blood Incompatibility, Air Embolism, and Falls and Trauma—because no measures in other CMS quality programs cover these topics.

CMS previously calculated and reported four other DRA HAC measures in 2013: (1) Pressure Ulcer Stages III or IV, (2) Manifestations of Poor Glycemic Control, (3) Catheter-Associated Urinary Tract Infections, and (4) Vascular Catheter-Associated Infections. CMS also previously calculated and reported PSI 11 (Postoperative Respiratory Failure Rate). CMS no longer reports these other measures to reduce redundancy among its quality reporting programs. National Quality Forum (NQF)-endorsed measures address many of the same concepts. For example, the CMS PSI 90 measure includes information on two of the concepts (i.e., pressure ulcers and postoperative respiratory rate). The Centers for Disease Control (CDC) and Prevention's National Healthcare Safety Network (NHSN) central line-associated bloodstream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) measures also cover two concepts.

8. Can hospitals preview their results prior to public reporting?

Yes, hospitals have 30 days to preview their DRA HAC data and submit questions about their result calculations as needed prior to public reporting on the CMS website (https://data.cms.gov/) in August 2019. This is known as the Preview Period. CMS provides a Hospital-Specific Report (HSR) via the *QualityNet Secure Portal* at the beginning of the 30-day Preview Period in June 2019.

The Preview Period process does not allow hospitals to submit additional corrections related to the underlying claims data or add new claims to the data extract used to calculate the rates.

Please submit concerns or questions about your hospital's calculation via email to drahac@lantanagroup.com no later than 11:59 PM PT on the final day of the Preview Period. Include the subject line: "DRA HAC Preview Period Inquiry".

You can also submit your question via the Hospital Inpatient Q&A tool on *QualityNet* (https://cms-ip.custhelp.com/). Go to "Ask a Question" and select DRA HAC from the product list. New users need to create a new account.

Hospitals with no eligible discharges will not receive HSRs. CMS will exclude these hospitals from public reporting.

Do not email the HSR file, or its contents, because it contains personally identifiable information (PII). When referring to specific elements in the HSR, use the ID number in the first column of the worksheet.

9. What should a hospital do if a HAC is coded incorrectly?

A hospital has 60 days after the date of the notice of the initial assignment of a discharge to an MS-DRG to request a review of that assignment, as explained by CMS in the FY 2008 IPPS final rule (72 FR 47216), under 42 CFR 412.60(d). The hospital can submit additional information in its request.

A hospital that believes CMS incorrectly assigned a discharge to an MS-DRG may request review of the MS-DRG assignment by its fiscal intermediary or Medicare Administrative Contractor (MAC), consistent with Sec. 412.60(d) of the regulations.

CMS annually takes a "snapshot" of the claims data to perform measure calculations for quality reporting programs. CMS received a snapshot of the data on September 28, 2018 to perform calculations for 2019 DRA HAC Reporting.

The DRA HAC measure scores will only reflect edits that comply with the time limits and reopening and revision requirements outlined in the Medicare Claims Processing Manual: "Chapter 1 - General Billing Requirements," and "Chapter 34 - Reopening and Revision of Claim Determinations and Decisions."

Medicare Administrative Contractors (MACs) must have processed all corrections to underlying Medicare FFS claims data by the snapshot date. The HSR will not reflect any claim edits processed after this date. CMS cannot regenerate HSRs to reflect corrected claims.

The next claims snapshot for the claims-based measures, except for the Medicare Spending Per Beneficiary measure (MSPB), will be September 27, 2019 for 2020 DRA HAC Reporting.

10. When will CMS publicly release the DRA HAC data?

CMS will publicly report hospital-level DRA HAC measure rates on the CMS website (https://data.cms.gov) in August 2019. CMS will publicly report the rate of each DRA HAC measure for each hospital with eligible discharges.

Measure Methodology and Calculation Information

11. Which hospitals are included in the DRA HAC calculations?

The DRA HAC measures depend on complete and accurate coding of POA Indicator fields. Hospitals participating in the IPPS program and Maryland hospitals must submit complete POA coding. Although other types of hospitals can report POA indicators, CMS only calculates the DRA HAC measures for IPPS and Maryland hospitals.

The CMS HAC POA Indicators webpage provides a list of exempt hospital types under the link for Affected Hospitals (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/AffectedHospitals.html).

12. How does CMS calculate the DRA HAC measures?

CMS uses claims for Medicare Fee-for-Service (FFS) discharges between July 1, 2016 and June 30, 2018 to calculate the DRA HAC measure rates for 2019.

CMS reports the DRA HAC measures as observed rates (per 1,000 discharges). CMS divides the count of observed HAC occurrences identified at a hospital (numerator) by the number of eligible discharges at that hospital (denominator) and multiplies by 1,000.

13. Does CMS adjust these measures for a hospital's patient case-mix?

CMS does not adjust the DRA HAC rates for patient case-mix. Many of these measures are considered serious reportable events that should not occur, regardless of a patient's condition.

14. How does CMS process multiple HACs in the same claim when calculating hospital rates?

CMS' public reporting methodology for DRA HAC measures counts unique occurrences of HAC diagnosis codes. One discharge record may contain multiple HACs. CMS only counts one discharge record if it covers multiple diagnosis codes under the same HAC category.

15. Where can I find the ICD-10 codes used for 2019 DRA HAC Reporting?

Refer to the FY 2016, FY 2017, and FY 2018 ICD-10 HAC lists on the CMS website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html) for the complete lists of ICD-10 codes.

Discharges from July 1, 2016 through September 30, 2016 reference the FY 2016 ICD-10 HAC List. Discharges from October 1, 2016 through September 30, 2017 reference the FY 2017 ICD-10 HAC List. Discharges from October 1, 2017 through June 30, 2018 reference the FY 2018 ICD-10 HAC List on the cms.gov website.

16. Where can I find more information on the DRA HAC POA Indicators?

Visit CMS' HAC POA Indicator page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html) for more information. For general DRA HAC Reporting questions, visit the Hospital Inpatient Q&A tool on QualityNet (https://cms-ip.custhelp.com/) or email drahac@lantanagroup.com.